

# CARLOS I. FLORES, MD, PC

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## PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you or your *Notice of Privacy Practices*, a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

This is to certify that I, the above signed, hereby consent to and authorize the disclosure of any medical information to the following: (please circle)

FATHER

MOTHER

STEP-PARENT

GRANDPARENT

OTHER: (please specify) \_\_\_\_\_

If you do not want a certain disclosure made to the above, it is your responsibility to notify us in writing.